| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155526 | A. BUILDING 00<br>B. WING | 06/24/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PERSIMMON RIDGE REHABILITATION CENTRE | 200 N PARK ST<br>PORTLAND, IN47371 |

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| F0000 | This visit was for the Investigation of Complaint IN00092668.<br><br>Complaint IN00092668 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F224, F225, F226, F490.<br><br>Survey date: June 24, 2011<br><br>Facility number: 000148<br>Provider number: 155526<br>AIM number: 100275500<br><br>Surveyor: Randall Fry RN<br><br>Census bed type:<br>SNF/NF: 85<br>Total: 85<br><br>Census payor type:<br>Medicaid: 61<br>Medicare: 6<br>Other: 18<br>Total: 85<br><br>Sample: 3<br><br>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.<br><br>Quality review 6/28/11 by Suzanne | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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|---|---|---|---|---|
| | Williams, RN | | | |
| F0157 SS=D | A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br>Based on record review and interview, the facility failed to ensure the physician was notified of a change in condition for 1 of 3 residents reviewed for physician notification in a sample of 3 (resident A). | F0157 | 1. The physician for Resident A was updated on June 17, 2011 regarding the resident's condition.2. All other residents have the potential to be affected. The clinical records have been reviewed for all residents, and if a change of condition was noted | 07/08/2011 |

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| | Findings include:<br><br>Review of the clinical record for resident A on 6/24/11 at 1:00 PM, indicated the resident was admitted to the facility on 9/20/10. Resident A had diagnoses' including, but not limited to: paranoid schizophrenia, anxiety, and depression. A history and physical exam dated 9/7/10 indicated the resident had a history of alcohol abuse.<br><br>Review of the clinical record for resident A on 6/24/11 at 1:00 PM, included the following nursing notes:<br>"6/16/11 at 10:30 PM: Resident returned from LOA (leave of absence). Resident in wheel chair with 02 (oxygen) on at two liters per minute via nasal cannula. Portable 02 tank on back of wheel chair. CNA took resident to room to assist to bed."<br>"6/16/11 at 11:00 PM: Summoned to resident's room by CNA. Resident states I'm so sorry. Resident had vomited clear liquid with black flecks. Emesis covers blouse, front of slacks and is in a large puddle on floor. Resident looks at writer and CNA repeatedly stating I love you, you are so beautiful. Assisted resident with removing clothes. Put gown on assisted to bed. Side rail up and call light within reach. Resident again states I'm so sorry I had some drinks...resident has no | | the primary physician was notified as indicated.3. The facility's policy for Physician Notification (See Attachment A) has been reviewed and no changes are indicated at this time. The nurses have been re-educated on physician notification related to change of condition. (See Attachment B). A nurses notes review form has been initiated to ensure physician notification is done (See Attachment C).4. The DON or designee will review nurses notes five days per week on scheduled work days for all residents and will complete the nurses notes review form for a minimum of 6 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly. 5. The above corrective actions will be completed on or before July 8, 2011. | |

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| | complaints of pain or discomfort. Pleasant, smiling and smells of alcohol." "6/17/11 at 2:00 AM: Resident resting in bed in supine position. HOB (head of bed) elevated, respirations 18, even and unlabored." "6/17/11 at 9:00 AM: Resident consumed 75% and 480 cc (cubic centimeters) of breakfast without any difficulty, no emesis noted, states I'm just a little tired." "6/17/11 at 10:45 AM: (Physician) made aware of previous outing with no new orders at this time."<br><br>The clinical record for resident A did not have documentation the physician was notified of this resident's condition prior to 6/17/11 at 10:45 AM.<br><br>The clinical record for resident A did not have documentation of a physician's order to consume alcoholic beverages prior to 6/17/11.<br><br>An interview with the facility Director of Nursing and the Corporate Nurse Consultant, on 6/24/11 at 2:00 PM, indicated there was no documentation the physician was notified prior to 6/17/11 at 10:45 AM.<br><br>This deficiency is related to Complaint IN00092668. | | | |

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| | 3.1-5(a)(2) | | | |
| F0224 SS=D | The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br>Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed for abuse/mistreatment in a sample of 3, was not mistreated by facility staff (resident A).<br><br>Findings include:<br><br>Review of the clinical record for resident A on 6/24/11 at 1:00 PM, indicated the resident was admitted to the facility on 9/20/10. Resident A had diagnoses including, but not limited to: paranoid schizophrenia, anxiety, and depression. A history and physical exam dated 9/7/10 indicated the resident had a history of alcohol abuse.<br><br>Review of a facility incident report dated 6/17/11 on 6/24/11 at 12:05 PM, included the following: "...Incident occurring on 6/16/11 involving (resident A), (The facility Administrator), and (the Activity Director). (the Administrator and the Activity Director) took (resident A) to a bar...on June 16, 2011 per (resident A) | F0224 | 1. Resident A is her own responsible party and signed out of the facility to go to a bar to celebrate her birthday with the Administrator and Activity Director. Upon return to the facility, Resident A experienced an emesis episode. Resident A was cleaned up, assisted to bed, and safety was ensured. The Administrator and Activity Director have been terminated.2. All other residents have the potential to be affected. See below for corrective measures.3. The facility's policy for Abuse (Mistreatment) has been reviewed and no changes are indicated at this time (See Attachment D). The facility staff, including the new Administrator and Activity Director, have been re-educated on abuse and mistreatment (See Attachment E). An Abuse Monitoring form (See Attachment F) has been intiatied to ensure abuse/mistreatment does not occur.4. The Administrator or designee will complete the Abuse Monitoring form daily on scheduled work days for a minimum of 6 months. The Regional Director and/or Nurse | 07/08/2011 |

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| | request for her birthday. (Resident A) signed herself out at 6:00 PM, and was brought back to the facility at 10:30 PM...Resident statement: "(Resident A) indicated she had a good time. Said she drank five whiskey and cokes and some other drinks. Indicated the other drinks had to have slow gin in them as that sneaks up on you. Indicated she drank 8-9 drinks for her birthday."<br><br>Review of the nursing notes for resident A included the following:<br>"6/16/11 at 10:30 PM: Resident returned from LOA (leave of absence). Resident in wheel chair with 02 (oxygen) on at two liters per minute via nasal cannula. Portable 02 tank on back of wheel chair. CNA took resident to room to assist to bed."<br>"6/16/11 at 11:00 PM: Summoned to resident's room by CNA. Resident states I'm so sorry. Resident had vomited clear liquid with black flecks. Emesis covers blouse, front of slacks and is in a large puddle on floor. Resident looks at writer and CNA repeatedly stating I love you, you are so beautiful. Assisted resident with removing clothes. Put gown on assisted to bed. Side rail up and call light within reach. Resident again states I'm so sorry I had some drinks...resident has no complaints of pain or discomfort. Pleasant, smiling and smells of alcohol." | | Consultant will review this form at least twice monthly for two months, then monthly for at least 4 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.5. The above corrective actions will be completed on or before July 8, 2011. | |

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| | "6/17/11 at 2:00 AM: Resident resting in bed in supine position. HOB (head of bed) elevated, respirations 18, even and unlabored."<br>"6/17/11 at 9:00 AM: Resident consumed 75% and 480 cc (cubic centimeters) of breakfast without any difficulty, no emesis noted, states I'm just a little tired."<br>"6/17/11 at 10:45 AM: (Physician) made aware of previous outing with no new orders at this time."<br>"6/17/11 at 12:30 PM: Telephone order received per (physician). May have alcoholic beverages in moderation PRN (as necessary)..."<br><br>A physician's order dated 6/20/11 included: "Discontinue order may consume alcoholic beverages in moderation PRN. Resident may consume two alcoholic beverages daily PRN."<br><br>The clinical record for resident A did not have documentation of a physician's order to consume alcoholic beverages prior to 6/17/11.<br><br>An interview with the facility Regional Director of Operations on 6/24/11 at 12:50 PM, indicated the Activity Director's employment had been terminated after this incident, and the facility Administrator was currently on administrative leave pending a decision | | | |

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| | about disciplinary action regarding this incident. The Regional Director of Operations indicated the resident was alert and oriented, was her own person, and did not have a Power of Attorney or Health Care Representative.<br><br>This deficiency is related to complaint IN00092668.<br><br>3.1-28(a) | | | |

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| F0225 SS=D | The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | | | |
| | Based on record review and interview, the facility failed to report an incident involving mistreatment of a resident to the Indiana State Department of Health and other officials in accordance with state | F0225 | 1. The incident involving Resident A was reviewed with the the legal department and per discussion, felt it did not meet the ISDH reportable guidelines (See Attachment G). The facility has | 07/08/2011 |

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| | law for 1 of 3 residents reviewed for reporting abuse/mistreatment in a sample of 3. (Resident A).<br><br>Findings include:<br><br>Review of the clinical record for resident A on 6/24/11 at 1:00 PM, indicated the resident was admitted to the facility on 9/20/10. Resident A had diagnoses including, but not limited to: paranoid schizophrenia, anxiety, and depression. A history and physical exam dated 9/7/10 indicated the resident had a history of alcohol abuse.<br><br>Review of a facility incident report dated 6/17/11 on 6/24/11 at 12:05 PM, included the following: "...Incident occurring on 6/16/11 involving (resident A), (The facility Administrator), and (the Activity Director). (the Administrator and the Activity Director) took (resident A) to a bar...on June 16, 2011 per (resident A) request for her birthday. (Resident A) signed herself out at 6:00 PM, and was brought back to the facility at 10:30 PM...Resident statement: "(Resident A) indicated she had a good time. Said she drank five whiskey and cokes and some other drinks. Indicated the other drinks had to have slow gin in them as that sneaks up on you. Indicated she drank 8-9 drinks for her birthday." | | reported the incident to the HFA board (See Attachment H), and per the state surveyor's recommendations, the facility has also reported the incident to ISDH on June 30, 2011.2. All incidents have been reviewed, and if they meet the ISDH reportable guidelines, have been reported to ISDH and other officials in accordance with state law.3. The facility's policy for reporting incidents to ISDH has been reviewed and no changes are indicated at this time (See Attachment I). The DON and new Administrator have been educated on the reporting guidelines (See Attachment J). An Abuse Monioring form (See Attachment E) has been initiated to ensure incidents are reported per policy.4. The Administrator or designee will complete the abuse monitoring form daily on scheduled work days for a minimum of 6 months. The Regional Director and/or Nurse Consultant will review this form at least twice monthly for two months, then monthly for at least 4 months. These reviews will be discussd during the facility's quarterly QA meetings and the plan adjusted accordingly.5. The above corrective actions will be completed on or before July 8, 2011. | |

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| | Review of the nursing notes for resident A included the following:<br>"6/16/11 at 10:30 PM: Resident returned from LOA (leave of absence). Resident in wheel chair with 02 (oxygen) on at two liters per minute via nasal cannula. Portable 02 tank on back of wheel chair. CNA took resident to room to assist to bed."<br>"6/16/11 at 11:00 PM: Summoned to resident's room by CNA. Resident states I'm so sorry. Resident had vomited clear liquid with black flecks. Emesis covers blouse, front of slacks and is in a large puddle on floor. Resident looks at writer and CNA repeatedly stating I love you, you are so beautiful. Assisted resident with removing clothes. Put gown on assisted to bed. Side rail up and call light within reach. Resident again states I'm so sorry I had some drinks...resident has no complaints of pain or discomfort. Pleasant, smiling and smells of alcohol."<br>"6/17/11 at 2:00 AM: Resident resting in bed in supine position. HOB (head of bed) elevated, respirations 18, even and unlabored."<br>"6/17/11 at 9:00 AM: Resident consumed 75% and 480 cc (cubic centimeters) of breakfast without any difficulty, no emesis noted, states I'm just a little tired."<br>"6/17/11 at 10:45 AM: (Physician) made aware of previous outing with no new | | | |

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| | orders at this time."<br>"6/17/11 at 12:30 PM: Telephone order received per (physician). May have alcoholic beverages in moderation PRN (as necessary)..."<br><br>A physician's order dated 6/20/11 included: "Discontinue order may consume alcoholic beverages in moderation PRN. Resident may consume two alcoholic beverages daily PRN."<br><br>The clinical record for resident A did not have documentation of a physician's order to consume alcoholic beverages prior to 6/17/11.<br><br>An interview with the facility Regional Director of Operations on 6/24/11 at 12:50 PM, indicated the facility had not reported this incident because the facility attorney had advised them this incident did not require reporting to any state agency; however; the facility was planning to provide a summary of this incident to the Indiana Health Facility Administrators Board.<br><br>This deficiency is related to complaint IN00092668.<br><br>3.1-28(c)<br>3.1-28(e) | | | |

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| F0226 SS=D | The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br>Based on record review and interview, the facility failed to follow their policy and procedure for reporting an incident involving mistreatment of a resident to the Indiana State Department of Health and other officials in accordance with state law for 1 of 3 residents reviewed for reporting abuse/mistreatment in a sample of 3. (Resident A).<br><br>Findings include:<br><br>Review of a facility incident report dated 6/17/11 on 6/24/11 at 12:05 PM, included the following: "...Incident occurring on 6/16/11 involving (resident A), (the facility Administrator), and (the Activity Director). (The Administrator and the Activity Director) took (resident A) to a bar...on June 16, 2011 per (resident A) request for her birthday. (Resident A) signed herself out at 6:00 PM, and was brought back to the facility at 10:30 PM...Resident statement: "(Resident A) indicated she had a good time. Said she drank five whiskey and cokes and some other drinks. Indicated the other drinks had to have slow gin in them as that sneaks up on you. Indicated she drank 8-9 | F0226 | 1. The incident involving Resident A was reviewed with the legal department and per discussion, felt it did not meet the ISDH reportable guidelines (See Attachment G). The facility has reported the incident to the HFA board (See Attachment H) and per the state surveyor's recommendations, the facility has also reported the incident to ISDH on June 30, 2011.2. All incidents have been reviewed, and if they meet the ISDH reportable guidelines, have been reported to ISDH and other officials in accordance with state law.3. The facility's policy for reporting incidents to ISDH has been reviewed and no changes are indicated at this time (See Attachment I). The DON and new Administrator have been educated on the reporting guidelines (See Attachment J). An Abuse Monitoring form (See Attachment E) has been initiated to ensure incidents are reported per policy. The Regional Director and/or Nurse Consultant will review this form at least twice monthly for two months, then monthly for at least 4 months.4. The Administrator or designee will complete the abuse monitoring form daily on scheduled work days for a minimum of 6 months. | 07/08/2011 |

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| | 155526 | A. BUILDING 00<br>B. WING | 06/24/2011 |

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| | drinks for her birthday."<br><br>The record for Resident A was reviewed on 6/24/11 at 1:00 PM. Review of the nursing notes for resident A included the following:<br>"6/16/11 at 10:30 PM: Resident returned from LOA (leave of absence). Resident in wheel chair with 02 (oxygen) on at two liters per minute via nasal cannula. Portable 02 tank on back of wheel chair. CNA took resident to room to assist to bed."<br>"6/16/11 at 11:00 PM: Summoned to resident's room by CNA. Resident states I'm so sorry. Resident had vomited clear liquid with black flecks. Emesis covers blouse, front of slacks and is in a large puddle on floor. Resident looks at writer and CNA repeatedly stating I love you, you are so beautiful. Assisted resident with removing clothes. Put gown on assisted to bed. Side rail up and call light within reach. Resident again states I'm so sorry I had some drinks...resident has no complaints of pain or discomfort. Pleasant, smiling and smells of alcohol."<br>"6/17/11 at 2:00 AM: Resident resting in bed in supine position. HOB (head of bed) elevated, respirations 18, even and unlabored."<br>"6/17/11 at 9:00 AM: Resident consumed 75% and 480 cc (cubic centimeters) of breakfast without any difficulty, no | | The Regional Director and/or Nurse Consultant will review this form at least twice monthly for two months, then monthly for at least 4 months. These reviews will be discussd during the facility's quarterly QA meetings and the plan adjusted accordingly.5. The above corrective actions will be completed on or before July 8, 2011. | |

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| | emesis noted, states I'm just a little tired." "6/17/11 at 10:45 AM: (Physician) made aware of previous outing with no new orders at this time." "6/17/11 at 12:30 PM: Telephone order received per (physician). May have alcoholic beverages in moderation PRN (as necessary)..."<br><br>A physician's order dated 6/20/11 included: "Discontinue order may consume alcoholic beverages in moderation PRN. Resident may consume two alcoholic beverages daily PRN."<br><br>The clinical record for resident A did not have documentation of a physician's order to consume alcoholic beverages prior to 6/17/11.<br><br>Review of the current facility policy and procedure for abuse prohibition, reporting, and investigation dated 1/06, and provided by the Director of Nursing on 6/24/11 at 1:50 PM, included, but was not limited to the following: "...2. (facility) will report all unusual occurrences, which includes abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health..."<br><br>An interview with the facility Regional Director of Operations on 6/24/11 at | | | |

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| | 12:50 PM, indicated the facility had not reported this incident because the facility attorney had advised them this incident did not require reporting to any state agency; however; the facility was planning to provide a summary of this incident to the Indiana Health Facility Administrators Board.<br><br>This deficiency is related to complaint IN00092668.<br><br>3.1-28(a) | | | |
| F0490 SS=D | A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed for mistreatment by staff in a sample of 3 (resident A), was not mistreated by the facility Administrator and the facility Activity Director.<br><br>Findings include:<br><br>Review of the clinical record for resident A on 6/24/11 at 1:00 PM, indicated the resident was admitted to the facility on 9/20/10. Resident A had diagnoses including, but not limited to: paranoid | F0490 | 1. Resident A is her own responsible party and signed out of the facility to go to a bar to celebrate her birthday with the Administrator and Activity Director. Upon return to the facility, Resident A experienced an emesis episode. Resident A was cleaned up, assisted to bed, and safety was ensured. The Administrator and Activity Director have been terminated and a new Administrator and Activity Director have been hired. 2. All other residents have the potential to be affected. See below for corrective measures. 3. The facility's policy | 07/08/2011 |

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| | schizophrenia, anxiety, and depression. A history and physical exam dated 9/7/10 indicated the resident had a history of alcohol abuse.<br><br>Review of a facility incident report dated 6/17/11 on 6/24/11 at 12:05 PM, included the following: "...Incident occurring on 6/16/11 involving (resident A), (the facility Administrator), and (the Activity Director). (the Administrator and the Activity Director) took (resident A) to a bar...on June 16, 2011 per (resident A) request for her birthday. (Resident A) signed herself out at 6:00 PM, and was brought back to the facility at 10:30 PM...Resident statement: "(Resident A) indicated she had a good time. Said she drank five whiskey and cokes and some other drinks. Indicated the other drinks had to have slow gin in them as that sneaks up on you. Indicated she drank 8-9 drinks for her birthday."<br><br>Review of the nursing notes for resident A included the following:<br>"6/16/11 at 10:30 PM: Resident returned from LOA (leave of absence). Resident in wheel chair with 02 (oxygen) on at two liters per minute via nasal cannula. Portable 02 tank on back of wheel chair. CNA took resident to room to assist to bed."<br>"6/16/11 at 11:00 PM: Summoned to | | for Abuse (Mistreatment) has been reviewed and no changes are indicated at this time (See Attachment D). The facility staff, including the new Administrator and Activity Director, have been re-educated on abuse and mistreatment (See Attachment E). An Abuse Monitoring form (See Attachment F) has been intiatied to ensure abuse/mistreatment does not occur. The Regional Director and/or Nurse Consultant will review this form at least twice monthly for two months, then monthly for at least 4 months.4. The Administrator or designee will complete the Abuse Monitoring form daily on scheduled work days for a minimum of 6 months. The Regional Director and/or Nurse Consultant will review this form at least twice monthly for two months, then monthly for at least 4 months. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.5. The above corrective actions will be completed on or before July 8, 2011. | |

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| | resident's room by CNA. Resident states I'm so sorry. Resident had vomited clear liquid with black flecks. Emesis covers blouse, front of slacks and is in a large puddle on floor. Resident looks at writer and CNA repeatedly stating I love you, you are so beautiful. Assisted resident with removing clothes. Put gown on assisted to bed. Side rail up and call light within reach. Resident again states I'm so sorry I had some drinks...resident has no complaints of pain or discomfort. Pleasant, smiling and smells of alcohol."<br>"6/17/11 at 2:00 AM: Resident resting in bed in supine position. HOB (head of bed) elevated, respirations 18, even and unlabored."<br>"6/17/11 at 9:00 AM: Resident consumed 75% and 480 cc (cubic centimeters) of breakfast without any difficulty, no emesis noted, states I'm just a little tired."<br>"6/17/11 at 10:45 AM: (Physician) made aware of previous outing with no new orders at this time."<br>"6/17/11 at 12:30 PM: Telephone order received per (physician). May have alcoholic beverages in moderation PRN (as necessary)..."<br><br>A physician's order dated 6/20/11 included: "Discontinue order may consume alcoholic beverages in moderation PRN. Resident may consume two alcoholic beverages daily PRN." | | | |

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| | The clinical record for resident A did not have documentation of a physician's order to consume alcoholic beverages prior to 6/17/11.<br><br>An interview with the facility Regional Director of Operations on 6/24/11 at 12:50 PM, indicated the Activity Director's employment had been terminated after this incident, and the facility Administrator was currently on administrative leave pending a decision about disciplinary action regarding this incident. The Regional Director indicated the facility was planning to provide a summary of this incident to the Indiana Health Facility Administrators Board.<br><br>This deficiency is related to complaint IN00092668.<br><br>3.1-13(q) | | | |